City of Wichita
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Employee Share of:	Premium PPO		Select PPO	
Single Premium	**$95.14/ month $47.57/ pay period**		**$29.80/ month $14.90/ pay period**	
Family Premium	**$284.68/ month $142.34/ pay period**		**$88.66/ month $44.33/ pay period**	
Benefit Level	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Deductibles	$0/ Individual $0/Family	$200 / Individual $400 / Family	$500/ Individual $1,000/Family	$1,000/Individual $2,000/Family
Coinsurance	0%	50%	20%	50%
Out of Pocket Maximum	None	Includes Coinsurance only $1,000 Individual $2,000 Family	Includes Deductible & Coinsurance $2,500 Individual $5,000 Family	Includes Deductible & Coinsurance $5,000 Individual $10,000 Family
Medical **Annual** **Lifetime**	**No Annual Maximum No Lifetime Maximum**			
Cochlear Implants & Services	**Limited to One Per Ear, Per Lifetime**			
Pharmacy **Lifetime**	**No Lifetime Limit**			
Physician Services	$20 Copayment	Deductible Plus 50% Coinsurance	$25 Copayment*	Deductible Plus 50% Coinsurance
Specialist Services	$20 Copayment	Deductible Plus 50% Coinsurance	$50 Copayment*	Deductible Plus 50% Coinsurance
Preventive Care	$20 Copayment	Deductible Plus 50% Coinsurance	Same as Office Visit*	Deductible and 50%
Prescription Drug Plan	$5 Generic Copayment $15 Brand Formulary Copayment $40 Brand Non-Formulary Copayment	$10 Generic Copayment $30 Brand-Formulary Copayment $80 Brand Non-Formulary Copayment	$10 Generic Copayment $25 Brand-Formulary Copayment $50 Brand Non-Formulary Copayment	$20 Generic Copayment $50 Brand-Formulary Copayment $100 Brand Non-Formulary Copayment
Formulary Generic **Formulary Brand** **Non-Formulary**	**SEE www.mycatamaranrx.com**			
Inpatient Hospital Services	$100 per Day Copayment up to a $500 maximum. $500 Inpatient Copayment limit per person per Calendar Year $1,000 Inpatient Copayment per Calendar Year	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
Outpatient Lab Services	$0 Copayment	Deductible Plus 50% Coinsurance	$0 Copayment	Deductible Plus 50% Coinsurance

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Hospital Outpatient Surgery and Scopes	$200 Copayment	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
Hospital Surgery and Scopes in an Ambulatory Surgery Center	$200 Copayment	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
Outpatient X-rays	$0 Copayment	Deductible Plus 50% Coinsurance	$0 Copayment	Deductible Plus 50% Coinsurance
Outpatient Diagnostic Testing and Services	$0 Copayment	Deductible Plus 50% Coinsurance	$0 Copayment	Deductible Plus 50% Coinsurance
Emergency Services At a Hospital Emergency Room (waived if admitted)	$100 Copayment for facility charges	$100 Copayment for facility charges	$150 Copayment for facility charges	$150 Copayment for facility charges
Ambulance Emergency Transportation (Ground or Air)	$0 Copayment	$0 Copayment	$0 Copayment	$0 Copayment
Urgent Care Facility	$20 Copayment	$20 Copayment	$50 Copayment	$50 Copayment
Short-Term Therapies Physical* Speech* Occupational* *Limited to 60 visits per Calendar Year*	$20 Copayment	Deductible Plus 50% Coinsurance	$50 Copayment	Deductible Plus 50% Coinsurance
Rehabilitation -Inpatient	$100 per Day Copayment up to a $500 Maximum *$500 Inpatient Copayment limit per person per Calendar Year* *$1,000 Inpatient Copayment per family per CalendarYear*	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
Rehabilitation - Partial Day Programs (4 hours or greater) *Limited to 60 visits per Calendar Year*	$20 Copayment	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
Outpatient Pulmonary & Cardiac *Limited to 60 visits per Calendar Year Benefit Maximum*	$20 Copayment	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
Home Health Care	$0 Copayment	Deductible Plus 50% Coinsurance	$0 Copayment	Deductible Plus 50% Coinsurance
Skilled Nursing Facility	$0 Copayment	Deductible Plus 50% Coinsurance	$0 Copayment	Deductible Plus 50% Coinsurance
Hospice	$0 Copayment	Deductible Plus 50% Coinsurance	$0 Copayment	Deductible Plus 50% Coinsurance
Durable Medical	$0 Copayment	Deductible Plus 50% Coinsurance	$0 Copayment	Deductible Plus 50% Coinsurance
Prosthetics & Braces	$0 Copayment	Deductible Plus 50% Coinsurance	$0 Copayment	Deductible Plus 50% Coinsurance

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Chiropractic Services / Spinal Manipulation *26 visits per Calendar Year*	$20 Copayment	No coverage for out-of-network providers	$25 Copayment	Not covered
Cochlear Implant *Limited to one implant per ear; per lifetime*	See Appropriate Benefits	Deductible Plus 50% Coinsurance	See Appropriate Benefits	Deductible Plus 50% Coinsurance
Organ Transplant	See Appropriate Benefits	Not Covered	See Appropriate Benefits	Not Covered
Transportation, Lodging & Meals when related to Organ Transplants	$0 Copayment *Limited to $2,000 per Calendar Year Benefit Maximum*	Not Covered	$0 Copayment *Limited to $2,000 per Calendar Year Benefit Maximum*	Not Covered
Mental/Nervous Treatment *Inpatient – Limited to 45 days per Calendar Year Benefit Maximum*	$100 per Day Copayment up to a $500 Maximum *$500 Inpatient Copayment limit per person per Calendar Year* *$1,000 Inpatient copayment per family per CalendarYear*	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
Mental/Nervous Treatment (continued) Outpatient *Limited to 45 visits per Calendar Year Benefit Maximum*	$20 Copayment	Deductible Plus 50% Coinsurance	$50 Copayment	Deductible Plus 50% Coinsurance
Substance Abuse & Chemical Dependency Inpatient *Limited to 30 days per Calendar Year Benefit Maximum*	$100 per Day Copayment up to a $500 Maximum *$500 Inpatient Copayment limit per person per Calendar Year* *$1,000 Inpatient Copayment per family per Calendar Year*	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
Substance Abuse & Chemical Dependency Outpatient	$20 Copayment	Deductible Plus 50% Coinsurance	$50 Copayment	Deductible Plus 50% Coinsurance
Injectable Medications Not listed elsewhere	$0 Copayment	Deductible Plus 50% Coinsurance	$0 Copayment	Deductible Plus 50% Coinsurance
Outpatient Dialysis	$0 Copayment	Deductible Plus 50% Coinsurance	$0 Copayment	Deductible Plus 50% Coinsurance
Infertility Includes diagnosis and diagnostic surgical treatment only	$20 Copayment	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance

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Nutritional Evaluation & Diabetes Management / Self-Training	$0 Copayment	Deductible Plus 50% Coinsurance	$0 Copayment	Deductible Plus 50% Coinsurance
Dental Services -Accidental Injury Limited to $1,000 per accident during a consecutive 12 month period	$0 Copayment	Deductible Plus 50% Coinsurance	$0 Copayment	Deductible Plus 50% Coinsurance
Impacted Wisdom Teeth Intraoral X-rays *When in connection with Covered oral surgery services*	Out of Network Deductible Plus 50% Coinsurance $0 Copayment	Out of Network Deductible Plus 50% Coinsurance $0 Copayment	Out of Network Deductible Plus 50% Coinsurance $0 Copayment	Out of Network Deductible Plus 50% Coinsurance $0 Copayment
Myofascial Pain & Temporomandibular Joint (TMJ) Dysfunction Syndromes	Out of Network Deductible Plus 50% Coinsurance	Out of Network Deductible Plus 50% Coinsurance	Out of Network Deductible Plus 50% Coinsurance	Out of Network Deductible Plus 50% Coinsurance

*****Please refer to the Summary Plan Description and applicable modified documents for complete benefits. This document is for discussion purposes only. ******

Notes

******* *Primary Care Physicians (PCP) generally include those physicians who practice in the specialties of Family Practice, Internal Medicine, General Practice, or Pediatrics. If you are not sure if a physician is a PCP, please contact the Customer Service Number on the back of your ID card. If you receive this service from a Primary Care Physician (PCP), your PCP payment will apply. If you receive these services from a Specialist, your Specialist payment will apply.*

***Please consult your Summary Plan Description and applicable modifications to determine the exact terms, conditions and scope of coverage including all exclusions and limitations. This summary is designed as a partial description of the plan being offered and in no way details all the benefits, limitations, or exclusions.*

To view the network, please go to www.chckansas.com. Select "PPO" for your "product type search."